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Certain Transparency Rules Delayed

Agencies Taking Additional Time to Finalize Certain Requirements

The U.S. Departments of Labor, Health and Human Services, and Treasury (collectively, the "Agencies") issued a set of Frequently Asked Questions (FAQs) delaying enforcement of several key group health plan transparency requirements a few months before the first were set to go into effect.

Employers, third party administrators (TPAs), and insurance carriers have been scrambling to navigate the transparency waters, made muddier by the fact that there are two separate sets of rules, each with different transparency requirements affecting group health plans:

1. **Transparency in Coverage Regulations** (TiC) published November 2020 that include requirements for non-grandfathered health plans under the Affordable Care Act and health plan issuers to make available:

   a) "Publicly available" machine-readable files disclosing in-network rates, out-of-network allowed amounts, and billed charges for medical coverage and prescription drug pricing; and

   b) An internet-based self-service tool that participants can use to obtain an estimate of pre-treatment cost-sharing information for covered items and services.

2. **The No Surprises Act** (NSA), part of the Consolidated Appropriations Act, 2021[1] (which was passed after the TiC regulations were published), also includes some limited transparency requirements for group health plans:

   a) Prescription drug reporting;

   b) An advance explanation of benefits requirement; and

   c) Medical/Rx ID card disclosure requirements.[2]

If you think it sounds like there is overlap between the TiC and NSA, you are not alone. The Agencies have been contemplating the best way to reconcile the two, while minimizing the necessity for health plans and issuers to duplicate their efforts and seem to have decided that it will take some more time to figure it all out.

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[1] The No Surprises Act begins on page 4095.

[2] The NSA contains other transparency requirements not discussed in this alert, such as a removal of gag clauses preventing disclosure of certain pricing and quality information and a non-quantitative treatment (NQTL) analysis requirement for mental health and substance use disorder benefits. We addressed the NQTL requirement in an earlier alert.

Delayed Effective Date for Transparency in Coverage Regulations

The transparency regulations go into effect in three phrases from 2022 through 2024. Phase 1 was scheduled to be effective for plan years beginning on or after January 1, 2022, requiring non-grandfathered group health plans to disclose three separate sets of information via publicly available machine-readable files:

- Medical plan in-network rates;
- Medical plan out-of-network allowed amounts; and
- Prescription drug in-network rates and historical pricing.

The FAQs delayed the effective date for the medical plan files for plan years beginning January 1, 2022 – June 30, 2022 until **July 1, 2022**. The FAQs delay the prescription drug file requirement **until further notice** and indicate the Agencies may eliminate it if they determine it is redundant with the NSA's prescription drug reporting requirement.

Phases 2 and 3 of the TiC require the implementation and delivery of electronic cost estimate tools for covered services. These phases go into effect in 2023 and 2024, respectively, and the FAQs did not delay them.[3]

Note: The TiC rules affect group health plans as well as health insurance issuers (carriers). Although the plan sponsor (employer) is ultimately responsible for compliance, we believe insurance carriers will handle the required disclosures and tools for fully insured coverage since they are also subject to the regulations. Self-insured plans may contractually shift the compliance responsibility to a third party administrator (TPA). We recommend that all employers review their vendor contracts to determine existing responsibilities and whether to delegate certain compliance obligations.

Machine Readable Files

The TiC regulations require plans and issuers to publish and host "publicly available" machine-readable files, but do not let the term mislead you. The purpose of the files is to provide transparency within the insurance industry, and the data and format will be meaningless to the average consumer.

Plan sponsors (employers) must ultimately provide certain data elements to the insurer/ TPA to build those files and determine who will host them. If a plan sponsor changes insurers/TPAs mid-year, the plan sponsor will likely have separate files for each portion of the year. If the insurer/TPA will host the files, we recommend that service agreements indicate the following:

- The insurer/TPA will continue hosting the publicly available file through at least the end of the current calendar year, and
- The insurer/TPA will continue to maintain the file for a specified period.[4]

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[3] We addressed the TiC's three phases in an earlier alert.

[4] Since the TiC regulations include revisions to ERISA's regulations, maintaining these files for up to six years after the end of the year may be plausible in keeping with ERISA's recordkeeping requirement for plan materials.

Delayed Effective Date for Certain No Surprises Act Transparency Requirements

Prescription Drug Reporting

Under the No Surprises Act, non-grandfathered group health plans providing prescription drug coverage must report certain demographic and plan cost information to the Agencies. Some of the required information is the same as that required to be included in the TiC's machine-readable files for prescription drug coverage.

NSA reports will be due June 1st each year for the prior plan year. The initial report was supposed to be due December 27, 2021 for the 2020 plan year. The FAQs delayed the December 27, 2021 and June 1, 2022 reporting deadlines until further notice, although the guidance indicates parties should prepare to complete both 2020 and 2021 reporting by **December 27, 2022.**

We expect the 2022 reporting will be due by June 1, 2023, as originally intended. Guidance addressing reporting specifics and a template are not available and may be months away.

Advance Explanations of Benefits

The NSA also contains a requirement for plans to provide participants with an advance explanation of benefits (EOB) upon receipt of a good faith estimate of expected charges from a health care provider in anticipation of receipt of a particular item or service. The advanced EOB requirement has two moving parts:

1. **Provider notice to group health plans (or insurers for individual policies)**

   When an individual schedules a service with a health care provider (or requests an advance determination of cost), the health care provider must ask if the individual has health insurance. If the answer is yes, the provider must obtain the individual's health insurance information and send a good-faith estimate of the projected costs to the health plan. If the individual does not have health insurance and is not a Medicare, Medicaid, or other federal program enrollee, the provider will send the estimate to the individual.

2. **Advanced explanation of benefits (EOB) to participant**

   Once a health plan receives an estimate from a provider, it must provide the participant with a notice addressing the following (in easy to understand terms):

   - Whether the provider is in-network, and if so, the contracted in-network rate for the item or service;
   - If the provider is out-of-network, information about how to find in-network providers;
   - The good-faith estimate amount quoted by the provider;
   - A good-faith estimate of the amount the plan will pay and the participant's out-of-pocket expense (taking year-to-date accumulators into account); and
   - A disclaimer about any medical management techniques that will apply to the service (e.g. prior authorization, concurrent review, etc.).

The advance EOB requirement was supposed to be effective for plan years beginning on or after January 1, 2022. The FAQs delayed this **until further notice**, but HHS stated it will "investigate whether interim solutions are feasible for insured consumers." We suspect the federal agencies intend to modify the TiC advance cost tool requirement to also address the NSA criteria and will eliminate the advance EOB requirement. This should mean an overall effective date for plan years beginning on or after **January 1, 2023** (the Phase 2 effective date under the TiC regulations).

Medical/Rx Plan ID Card Disclosure

For plan years beginning on or after **January 1, 2022**, the NSA also mandates medical/Rx plan[5] ID cards to list certain information—applicable deductible and out-of-pocket maximum limitations as well as a telephone number and website contact information for individuals to be able to obtain assistance. The FAQs did not delay this disclosure, but they did indicate the Agencies will not publish guidance before the effective date and plans must make a good faith effort to comply in the meantime.[6]

So far, insurance carriers appear to be preparing to update electronic versions of ID cards now and will provide updated hard copies later as a good faith compliance effort. We believe this approach satisfies the good faith standard.

The NSA and existing guidance do not clearly address what to do about carved-out prescription drug (Rx) coverage integrated into a medical plan (i.e., a participant must elect medical coverage to receive Rx coverage) with its own ID card, and we do not expect additional guidance for months. For now, we believe the medical/Rx plan acts in good faith if:

1. The Rx ID card discloses a website that hosts the Rx limits; and/or
2. The Rx limits exist on the same website as any other medical plan limits disclosed by the medical plan ID card.

Options #1 and #2 can both be used and link to the same website. If an employer offers Rx coverage as a separate, standalone group health plan, which is very rare, it is clear the reporting rule will apply to the plan's ID card for plan years beginning on or after **January 1, 2022**.

While less frequent, this discussion also applies to other carved-out benefits using ID cards.

Next Steps

Employers with calendar year plans should contact their insurance carriers, TPAs, and/or other vendors now to make sure that they will issue compliant physical and/or electronic medical/Rx plan ID cards for plan years beginning on or after January 1, 2022.

Plans (and carriers/TPAs) have some time to work on the machine-readable file requirement – we suspect the Agencies will drop the Rx file requirement – before the July 1, 2022 effective date. Additional guidance and clarity addressing the requirements will be very welcome.

We are aware that carriers/TPAs are beginning to distribute solutions for most of the transparency requirements with fee schedules, and we recommend employers review this information and begin making decisions. In most instances, we believe delegating this responsibility to the carrier/TPA for a fee is the better option.

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[5] The disclosure applies to group health plans, but it: (1) only applies to plans that use insurance ID cards (and does not force this on other plans); and (2) excludes excepted benefits. This effectively limits the disclosure to medical/Rx coverage.

[6] As noted in the FAQs, a plan complies in good faith if the ID card lists the medical plan's primary deductible and out-of-pocket maximum limit and reserves other deductible and out-of-pocket maximum limit information to the website.

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